MENTAL HEALTH OF YOUTH IN THE COVID CAPITAL OF INDIA: MAHARASHTRA

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Abstract

The Coronavirus Disease-2019 outbreak brought along a set of unprecedented challenges affecting virtually all domains of human life. The mental health of the youth has been one major area of concern. There are various factors that determined how the pandemic was received by the diverse population of the country. This study is a postlude to an already conducted primary study and throws light on the status of the mental health of youth in one of the country's worst affected states, Maharashtra. A sample of 567 youth was studied from various parts of Maharashtra and multiple streams of education representing different genders, family structures and social support. This paper is an enquiry in the levels of Anxiety, Depression, Stress and Well-being among youth from various backgrounds. In the context of the Pandemic, major mental health consequences were felt in the country; youth taking higher education were exposed to 'a new normal' of online education and uncertainty. Despite the fact that mental distress like anxiety, depression and stress is a prevalent theme among this population, there has been a dearth of formal records of the same. This research uses a sequential mixed method design wherein the participants of the study were interviewed and an account of their experiences during the pandemic was documented through individual interviews and thematic content analysis. The current study aims to bridge this gap and pose an inquiry about the reasons for the same, so that better sensitization and mitigation strategies may be developed and implemented at a policy level to guard the mental well-being of our most valuable resource "youth". The obtained results show an interesting trend among the population pertaining to their area of residence, availability of space, gender differences, the type of family and perceived social support. Significant differences were obtained for the scores on Depression, Anxiety, Stress and Well Being. The results obtained could go a long way in bolstering mental health training modules. Relevant modifications could be done to existing Disaster Management Policies to ensure holistic effectiveness of the program. Additional findings are also discussed.

Keywords: COVID-19 Pandemic, Youth, Stress, Depression, Anxiety, Mental Health, Maharashtra, Urban, Rural, Nuclear Family, Joint Family.

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Introduction

Coronavirus Disease-2019 the biggest global crisis in generations rattled the world with its far reaching and severe repercussions. Expeditious human to human transmission created an environment of fear, anxiety, loneliness, stress and in some cases even xenophobia (Javed, Sarwer, Soto & Mashwani,2020). The outbreak and its consecutive waves left the people with extreme anxiety, anger, denial, depression, substance use, self-harm and even suicide among quarantined individuals (Li, Yang, Liu, Zhao, Zhang, Chung & Xiang, 2020; Goyal, Chauhan, Chikara, Gupta & Singh, 2020). The horrors of pandemic spread rapidly, and each wave made the challenges even tougher. No one was immune. There was nothing which could have prepared the country from the onslaught of the pandemic, especially the second wave. Fear of getting infected, death of loved ones, social isolation and stigmatization caused grave distress among all age groups and youth were no exception. Social distancing, online classes, career uncertainties and financial worries took a major toll on their mental health.

The uncertainties triggered by the pandemic not only affected the daily life functioning of youth but also prompted further delays in academic activities which can directly aggravate stress in students (Cao, Fang, Hau, Han, XU, Dong, 2020). Also lack of involvement in academic activities and absolute absence of usual academic environment led to lack of routine, reduced physical activities and social media addiction among students (Chhetri, Goyal, Mittal, Battineni, 2021). Overloading and overwhelming information called 'infodemic' via social media platforms created anxiety, confusion and worry among people while risking the spread of false information (Fiorillo & Gorwood, 2020). Even according to United Nations Children's Fund (UNICEF) reports, every 7th Indian youth has suffered from depression during COVID-19 (Times of India , 2021).

Though the entire nation faced the brunt of the pandemic, the Maharashtra state was the most affected. Maharashtra alone accounted for 24% of the total number of cases in India and was called the COVID capital of the country. Till November 2022, 8134440 total confirmed cases of COVID were reported in Maharashtra and a total 148401 deaths have been recorded (Govt of India, 2022). Maharashtra's large population size living in close proximity most likely contributed predominantly to the spread. More than half of the COVID-19 cases of Maharashtra were being reported from four major cities Mumbai, Thane, Nagpur and Pune. This typically alerts that the extent of urbanization could have been one of the most important determinants of COVID-19 morbidity (Awate, 2021).

All the sections of the society were affected massively, the vulnerable groups faced the impact massively and the youth were the hardest hit (Sebastien, 2021). Narayanan & Sriram (2021) reported prevalence of depression rates in youth as 51.8 percent. Research also verified that female students in the age group of 16 to 25 had increasing concerns about their health and future and are more vulnerable to feelings of uncertainty and helplessness when compared to males. Males were also found to have higher need for seclusion, withdrawal and ideation of self-harm (Moghe, Kotecha & Patil,2021; Gore, Gajare & Swamy,2020). Research also shows that urban students' population is more mentally affected when compared to rural students (Moghe, Kotecha & Patil,2021; Kumar, Mazumdar, Choudhary & Dhull, 2022).

It goes unchallenged that pandemic affects both physical and mental health of masses however in actuality when physical health is at threat mental health care sounds a luxury rather than necessity to many. But the fact remains that the long-fought battle against the physical and social impacts of COVID-19 has proven that self-care and public mental health was neither early nor today is a luxury and rather a necessity for all age groups specifically when the psychological impacts of pandemic are likely to linger. However, the greatest irony for years is that in a country with the maximum youth population we do not even have a theory or framework concerning the healthy mental growth of this

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population, in addition to the fact that we do not have many effective interventions aimed at ensuring the mental wellbeing of the youth (Bang, 2021). According to the National Crime Records Bureau (2021), a total of 1,64,033 suicides were reported in the country during 2021. There was also an increase in suicide rates by 7.2 percent as compared to 2020. This number has also preceded the earlier years. According to the reports, Maharashtra has the highest percentage share in suicide cases during 2019-2021. Even after all these alarming figures, out of 73,931 crore rupees (8.9 billion USD) sanctioned for Health & Family welfare in the annual budget of 2023; only 0.81percent has been allocated to mental health. In a country where 14 percent of the total population is suffering from mental health issues and where there is a treatment gap of 72 – 90 percent; will this budget allocation make any difference at all ? (Mahashur & Fernandes, 2023)

Where the pandemic worsened the mental health conditions in India it also has thrust upon us the need to make mental health a priority and to foster the equality between physical and mental wellbeing. The present research thus attempts to verify the mental health status of youth in both rural and urban Maharashtra and investigate the plausible factors that must have steered the mental health deterioration among the youth in the COVID capital of India, Maharashtra. The right assessment of the mental health scenario and the major causal factors that dwindled the situation of youth in Maharashtra will pave the way for appropriate mitigation. This research study tries to find answers to these questions through both qualitative and quantitative methods.

Method

The aim of this study was to explore the mental health of the youth in the state of Maharashtra during the COVID-19 pandemic. A mixed methods sequential model was used with the intention to understand the unique experiences of youth residing in different parts of Maharashtra. This was done as an extension of a preliminary study done on a smaller sample. The population of students drawn from rural and urban backgrounds were compared on depression, anxiety, stress, perceived stress and well- being. The cross-sectional design was explored. Groups based on area of residence and structure of the family gave insights regarding significant differences. Additionally, qualitative data was gathered by conducting interviews of a smaller sub-section of the sample and they provided rich information about the struggles, challenges and also coping and resilience of the youth population.

Sample

The sample consisted of 582 respondents drawn from approximately 100 different villages, towns and cities in the Indian state of Maharashtra. In the quantitative phase of the study, after the outliers were removed, a sample of 567 was retained for data analysis. The students were from different streams and academic backgrounds of private and government colleges. Sampling technique used was purposive snowball sampling. The selection criteria were that they should be between the age group of 18 to 24 years, pursuing a full-time degree course that was conducted online at the time of data collection and must be residing in Maharashtra. The average age of the participants was 20.35 years.

A total of 377 students resided in the urban areas and 190 in the rural parts of the state of Maharashtra, India. As per the Census of India, 2001, the definition of ‘urban’ area adopted is as- minimum population of 5000, a density of population of at least 400 per/sq. Km., having municipality corporation, and at least 75% of male working population engaged in non- agricultural pursuits. On the other side, the majority of India lives in its “villages”; where localities are majorly engaged in agriculture and farming related activities. Here in this study it was referred to as the ‘rural’ area (Haub & Sharma,2006).

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308 were belonging to the nuclear family set- up; whereas 259 were from the joint family structure. A nuclear family is a family that includes a married couple and their off- spring/s, living under the same roof. A joint family consists of more than two generations staying together, including grandparents, parents, and children.

Psychometric Tools

Demographic Data

Demographic data were collected using a form specifically for the purpose of the present study. Participants were asked to provide their age, gender, year of study, family type, area of residence during pandemic.

Three standardized tools were selected by considering their applicability in catering the demands of this research study and respective psychometric properties. Considering their respective effectiveness, no changes were made in the original tools after the pilot study.

Considering that General Health WHO-5 is a globally recognized tool, it was used to screen general mental wellbeing. DASS-21 and PSS-10 were specifically selected as they avail the Indian norms recurred from the non-clinical population (Signh , Junnarkar & Sharma, 2015; Pangtey, Basu , Meena & Banerjee, 2020).

General Health WHO-5

A five-item questionnaire developed by the World Health Organization in the year 2004 was used to assess well- being of the participants. It uses a six-point Likert-type scale from 0 indicating “At no time”, 1, “Some of the time”, 2, “less than half the time” 3, 4, “more than half of the time”, 4, ‘most of the time” and 5, “all the time”. The test has a high construct validity that is established by its association with other measures of well-being. Higher score on the questionnaire indicates high well-being.

DASS-21

Depression Anxiety and Stress Scale- 21 developed by Lovibond and Lovibond (1995) was used. The 21-item scale measures depression (Items 3, 5, 10, 13, 16, 21), anxiety (2, 4, 7, 15, 19, 20) and stress (1, 6, 8, 11, 12, 14, 18). It uses a four-point Likert-type scale where 0 signifies “Did not apply to me at all”, 1, “Applied to me to some degree or some of the time”, 2, “Applied to me to a considerable degree or good part of the time” and 3, “Applied to me very much or most of the time”. The test has a good internal consistency with a Cronbach alpha of 0.8. Higher score on each dimension indicates a high phenomenon respectively.

Perceived Stress Scale (PSS 10)

Perceived Stress Scale developed by Cohen, Kamarck, and Mermelsten, (1983) was used to measure the subjective experience of stress among the population. The 10-item questionnaire uses a four-point Likert- type scale where 0 indicates, “never”, 1, “almost never”, 2, “sometimes”, 3, “fairly often” and 4, “very often”. The test has good psychometric properties and an internal consistency of 0.88.

Procedure

The present research was an extension of a pilot study done on a smaller sample after the proposal was approved by the Institutional Ethics Committee. In a similar manner, the necessary permissions from different colleges and universities across Maharashtra were taken. Background information of the study was provided before data collection and the duly filled informed consent forms were

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obtained. Considering the restrictions due to the pandemic times, the data was collected through 'online' mode by discussing details of the research study. Once the data was collected, a detailed online 'Mental Health Self- Care Program' was conducted for all the participants. For the qualitative analysis only extreme scoring participants were approached for the detailed interview after seeking their consent for the same. For the extreme scoring participants group counseling sessions were conducted post the qualitative interview. They were also given further professional references as needed.

The data collected was scanned for outliers using box plots and the final sample was put to data analysis using Excel 23 and SPSS V27. Further, by executing two- way MANOVA along with separate univariate ANOVAs, significant differences were confirmed.

After the data collection of the quantitative part of the study, online interviews of selected and consenting participants were conducted. A total of 28 students were selected from the sample. The parameter for selection was extreme scores on the measured variables. Out of these, 24 students gave their consent to participate in the interviews. A semi-structured interview schedule was curated to capture the various challenges faced by students during the pandemic and the lockdown that ensued. Questions like, what were the biggest challenges in dealing with the situation at that time? Which personal strengths helped you deal with it better? What kind of support did you get during these difficult times? Were being asked. Information about their primary coping mechanisms and social support was also recorded. Their suggestions for maintaining better mental health were also taken. These interviews were recorded and transcribed using Excel and the themes across interviews were drawn inductively.

Results

Descriptive statistics including mean and SD for focused dependent variables i.e. depression, anxiety, stress, perceived stress and well- being across four groups based on criteria of 'area of residence' (Urban / Rural) and 'structure of the family' (Nuclear / Joint) is summarized in table 1.

Table 1 Descriptive Indices for dependent variables with respect to Area of Residence & Family Structure (N= 567)

	Area of Residence				**Family Structure**			
	Urban		**Rural**		**Nuclear**		**Joint**	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Depression	6.27	5.40	4.61	4.73	6.30	5.11	5.02	5.31
Anxiety	4.57	4.62	3.04	3.89	4.45	4.48	3.59	4.36
Stress	7.26	5.63	6.18	5.80	7.56	5.83	6.11	5.47
Per. Stress	20.13	6.42	18.36	5.82	19.71	6.52	19.33	5.98
Well- Being	15.66	5.95	16.60	5.03	15.41	5.74	16.65	5.53

It has been observed that 'urban' youth has higher mean scores on depression, anxiety, stress and perceived stress as compared to 'rural' youth mean scores. Similar observations are there in case of youth belonging to 'nuclear' family structure as compared to youth belonging to 'joint' family structure. With respect to well- being scores, rural youth has higher mean score (16.60) in comparison

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to urban youth (15.66). Mean well- being scores are higher for youth belonging to joint family structure (16.65) in comparison to youth belonging to nuclear family structure (15.41).

Box's test analyzes the assumption of equal covariance matrices. This test is especially recommended when the group sizes differ. The value of significance for this test is more than .001. Hence, further to test the statistical significance between mean differences, two- way MANOVA was conducted. Main inferences are drawn based on Pillai's trace test (Field, 2013).

Table 2 MANOVA Summary for comparing all the DVs across Area of Residence & Family Structure.

Source	**V**	**F**	**p**
Area of Residence	.03	3.47	.004
Family Structure	.03	3.16	.008
AR X FS	.01	1.32	.25

According to table 2, there is a statistical significant difference on depression, anxiety, stress, perceived stress and well- being with respect to 'area of residence' of youth in Maharashtra (V=.03, F (5, 559) = 3.47, p=.004). It also revealed a statistical significant difference on these variables with respect to 'family structure' that youth belong to (V=.03, F (5, 559) = 3.16, p=.008). But no significant interaction effect was observed (V=.01, F (5, 559) = 1.32, p=.25). However, separate univariate ANOVAs on the outcome variables revealed varied results on the basis of both the criterion variables. Significant mean differences were observed on depression (F (1, 563) = 10.65, p = .001), anxiety (F (1, 563) = 13.41, p < .001) and perceived stress (F (1, 563) = 9.67, p = .002) on the basis of 'area of residence'; whereas on the basis of 'family structure', significant mean differences were observed on depression (F (1, 563) = 6.57, p = .01), stress (F (1, 563) = 4.72, p = .03) and well- being (F (1, 563) = 5.35, p = .02).

With this, four hypotheses have been significantly supported. 'Urban' youth in comparison to rural youth and youth belonging to 'nuclear family structure' in comparison to joint family structure has found to be high on depression, anxiety, stress and perceived stress. Whereas, 'rural' youth in comparison to urban youth and youth belonging to 'joint family structure' in comparison to nuclear family structure has found to be high on well- being.

Discussion

This research study explored the status of mental health of youth in Maharashtra, India, during COVID- 19 pandemic on the basis of mainly two criteria- first, their area of residence and secondly, the family structure that they belong to. Owing to the different challenges and variations in living conditions, it was hypothesized that there would be a difference in the mental health of the youth. Interestingly but not surprisingly, youth residing in an urban background found to be scoring higher on depression, anxiety, stress and perceived stress and lower on well- being as compared to youth residing in rural background. In the similar direction, the two- way MANOVA results confirmed a significant difference between youth belonging to nuclear families versus joint family structure. Additionally, youth from nuclear families exhibited greater mental distress and lower well-being than those from joint families. The MANOVA results saw significant differences in the area of residence and family structure but did not find any interaction.

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The findings seem consistent with prior research which has shown a higher prevalence of mental health problems among the urban population as compared to the rural population. This was due to factors like higher population density and possibility of contamination; which had been a greater concern in cities than in rural areas (Liu, 2021). The selected population are majorly city dwellers wherein the freedom of space was a luxury and often this population shared smaller city houses with the family with little or no moving space around (Morganti, 2022). Some researchers also observed that the impact on the source of income of the families has contributed to the existing anxiety and depression levels during the pandemic. Most of the population in the rural areas of India depends on agriculture and the allied industries which were considered as an essential service during the pandemic and hence the occupational activities did not slow down there; however, the same was not the case in the urban population, who heavily rely on a mixture of essential and non-essential industries. Exposure to the media and an extreme influx of unfiltered information has also led to anxiety among the urban population who were technologically better connected, exposing themselves to more fake news and conspiracy theories (Guan, 2021). A study by Salari (2020) concluded that there was a higher prevalence of mental symptoms among people with higher levels of education owing to increased awareness. They were also exposed more to the social media campaigns for resources which could have also put them at a higher risk of perceiving distress (Jiang, 2021). Meta-analysis emerging from pre and post pandemic longitudinal evidence pointed out internalizing and externalizing of psychological disorders, eating disorders, substance use and suicidality among the youth population (Chadi, Ryan & Geoffroy, 2022). The urban data here, which was collected majorly from the worst hit cities from Maharashtra which meant that the selected population have experienced the one of the most fatal impacts of the pandemic in the country (Debroi, 2021).

On the other hand, many students from a rural background have also expressed difficulties with uninterrupted internet connectivity, limiting access to information (Siddiqui, 2021). The same could have heavily contributed to general well- being which was found to be higher in the rural population as compared to the urban population. Another contributing factor can be a lower prevalence of COVID- 19 infections in the rural areas of India as compared to the urban counterparts. This was also noticed in the present study. About 50% of the urban sample reported that either they or one of the family members was infected by COVID -19, whereas only 19% incidence was reported in the rural population.

Another important aspect of this study came to fore as the ‘structure or type of the family’ that the youth belong to. Results showed that youth belonging to nuclear families were found to be higher on depression, anxiety, stress, perceived stress and lower on well- being as compared to youth belonging to joint family structure. Multiple research studies have shown the benefits that a joint family had over a nuclear family in tackling the novel pandemic. Joint families were better equipped in managing play behaviors, sleep habits, television watching (Tiwari 2020). Furthermore, family adaptability and cohesion has also been found to be greater in joint families as compared to nuclear families (Gopinath 2020). Furthermore, it has also been seen as a trend that joint families tend to have better dissipation of work and no one member feels responsible to work, earn or contribute emotionally in the family.

The findings of the study underscore the critical role of psychoeducation and barefoot counseling in mitigating the inimical effects of stress and anxiety specifically among the youth in academic setups. During uncertain periods, such as the pandemic, mental health is a significant concern and timely interventions offer valuable support in navigating difficult times. The research findings also highlight a significant treatment gap and accentuates the urgent need for timely mental health support and interventions, not only in urban areas but also in rural India.

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Qualitative Findings of the Study

Following is the discussion regarding qualitative analysis. Insights drawn from the detailed interviews have strengthened the findings of quantitative analysis. A set of eight questions were asked to twenty-one young adults. The interview provided the subjects flexibility and range which gave us a thorough understanding of the mental health challenges they faced during the pandemic. Below are the themes that emerged out of the thematic content analysis.

I) Quality Time with Family: Most of the participants spoke how the lockdown phase during the pandemic provided a lot of quality time to them. The time which in normal days would have been spent in commuting and juggling through the traffic was saved. Participants availed of the lockdown to spend quality time with their families.

"*I always wanted to do so many things however never had time, pandemic gave me the quality time to do that."* (Participant 1)

"There was lot of good time I got with my family. It was really good. After a long time, I got to spend so much time with my family at my village". (Participant 5)

"Spent lot of quality time with my grandparents. There were so many stories they used to tell which earlier I had very little time to listen." (Participant 10)

The location and activities seemed to matter as catch-up experiences, reconnecting with what was meaningful to quality of life.

II) Productivity: All the participants expressed how even with the stifling challenges experienced during the pandemic, it was deemed as a productive phase. As there was time which people invested in creativity and learning new things.

"*This was the most productive time for me. Cleared all my yoga levels in this time."* (Participant 3)

"I wanted to learn and practice meditation for a long time but couldn't but during COVID I got time to learn and practice meditation which I wanted for a very long time." (Participant 14)

"I started learning dance online which I had stopped earlier due to paucity of time." (Participant 4)

Interestingly, participants engaged in health and well-being promoting pursuits.

III) Uncertainty: All the participants mentioned how uncertainty regarding life ahead, career and academics was fuelling anxiety. They felt there was no clarity anymore on what the future would hold.

"The was so much confusion regarding examination, syllabus and mode of examination. There was uncertainty how it will all be and how will I be able to do that". (Participant 2)

"It was a very difficult time. So many people in the family got infected and I was uncertain when will all these challenges end". (Participant 18)

Studying as an endeavor lost its focus temporarily and was compounded by challenges about own health with household members being infected and not knowing about likely outcomes.

IV) Academic Challenges: Suddenly a long established system of classical teaching came to halt and something that academicians had never imagined "Online Classrooms" became an overnight reality. Pandemic was the time when the virtual mode of communicating and interacting was thrust upon everyone. Average forty-five-minute lecture to online examination everything was adding to the existing stress and fear. And the interviews verified how this posed a colossal challenge before the youth. Platforms such as Zoom, Google meet and WebEx became household names. Though online teaching was the only way out to bridge the gap, it also gave enormous stress to youth.

"The worst part of pandemic was online education and the problems it brought. Constant online, no axis to libraries, not able to meet the teachers in person". (Participant 2)

"The academic difficulties were there, exams got delayed and later the admission process was not clear. Admissions also got delayed. I had to start anxiety medication at that time". (Participant 3)

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"Second wave was the most depressing phase. I was not able to adapt to this mode of academics. It was so difficult to answer in an online class in front of fifty other people. Technical issues and network challenges added so much to the stress". (Participant 17)

Facing unprecedented challenges in their academic educational experiences on which youth did not have any control gave rise to emotional reactions, severe enough to seek medical interventions.

V) Helplessness: Another theme that emerged from the interviews was the feeling of helplessness. Pandemic brought the entire world on knees and everyone at some point felt helpless and youth were no exception. Helpless about isolation, the availability of daily resources, inability to reach out and help even to the closest ones, there was so much that made maintaining mental health a challenge.

"It was so difficult to stay indoors all the time. Every time I used to hear about someone getting infected and was unwell I felt helpless. There was nothing we could do to help." (Participant 5)

Aside from the internal psychological helplessness, there was also the reaction to lack of accessibility of essential medications, as illustrated in the example below.

"I was in my village so other things were okay but grocery items coming from city were falling short even the regular medicines. People who had cars could go and get the things but we could not". (Participant 16)

VI) Lack of Mental Health Support: The biggest challenge that emerged was of lack of mental health support at all rural and urban levels. The stress and anxiety were high but there was no awareness on whom to connect with and reach out to. There were many helplines and online counselling services available however not everyone was aware. Also, it is revealed from interviews that when to connect to a professional was also a doubt in the minds of many. Others bemoaned the lack of psychological help available.

"Lot of people don't even know that mental health is a concept and should be given importance to". (Participant 1)

"I left therapy due to financial issues. There should be free or minimally priced services for students to seek help". (Participant 4)

"I was in my village, so many time wanted to seek help but there was no psychological help available there". (Participant 12)

"There was no psychological help available when it was needed the most". (Participant 20)

The above themes clearly show that though quality time and productivity during the pandemic were big positives during the pandemic time, mental health management was still a challenge for most of the participants

The above discussed qualitative findings, obtained from in-depth interviews, provided further context and nuance to the quantitative findings. Participants from urban areas reported high levels of anxiety and stress, which aligns with the quantitative data. They expressed feelings of helplessness and uncertainty regarding their future, exacerbated by disruptions in education and limited access to mental health resources. On the other hand, rural participants found solace in spending quality time with family and engaged in productive activities, reflecting the higher well-being scores observed in the quantitative data. The mixed method approach helped understand the results better.

The quantitative results showed that urban youth had higher levels of depression, anxiety, and stress compared to their rural counterparts. This finding is supported by the qualitative data, where urban participants highlighted the negative impacts of living in densely populated areas with limited space and high media exposure. These factors likely contributed to their increased stress and anxiety. In contrast, rural youth benefited from a more stable environment with less media exposure and continued economic activity, contributing to their higher well-being. The qualitative feedback about quality family time and lower infection rates in rural areas aligns with the observed higher well-being

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scores. Further, quantitative analysis indicated that youth from nuclear families experienced higher levels of mental distress compared to those from joint families. This finding was corroborated by qualitative data, which highlighted the emotional and practical support provided by joint families during the pandemic. Participants from joint families reported better coping mechanisms and shared responsibilities, which likely mitigated the stress experienced. Conversely, the qualitative data revealed that youth from nuclear families faced additional stress due to increased individual responsibilities and less emotional support, reflecting the lower well-being scores seen in the quantitative analysis.

The integration of quantitative and qualitative findings provides a comprehensive understanding of the mental health challenges faced by youth during the COVID-19 pandemic. Urban youth experienced greater mental health issues, which were further elucidated by qualitative insights into their living conditions and stressors. Similarly, the benefits of joint family structures in managing stress were evident in both the quantitative data and qualitative experiences (Tiwari 2020). These findings underscore the importance of considering both statistical trends and personal experiences when addressing mental health disparities and developing targeted support interventions. Qualitative data revealed that some youth found engaging in productive activities—such as hobbies, learning new skills, and spending quality time with family—beneficial for their mental health. These activities contributed positively to their well-being and helped mitigate feelings of isolation and anxiety during the lockdown. Both urban and rural participants highlighted significant gaps in mental health resources. Despite the rural youth showing lower levels of mental health distress, the levels of distress present in both were significantly abnormal. This highlights the problem with limited access to mental health services. There is a noted issue with the accessibility, availability, and affordability of mental health resources.

These gaps underscore the need for improved mental health support in both urban and rural areas. The results of the research assert the dire need for effective policies governing the mental health aspect of youth and taking timely measures to bridge the treatment gap. There is also a need to come up with effective strategies to provide affordable therapy and counselling so that mental health becomes available to all the sections of society .

Conclusion

The obtained results show some thought-provoking trends among the population relating to their area of residence, availability of space, gender differences, the type of family and perceived social support. The ‘urban’ youth were high on depression, anxiety, stress and perceived stress as compared to ‘rural’ youth. The wellbeing of rural youth is found to be better than urban youth. Also, youth belonging to the joint family structure was higher on wellbeing than youth belonging to nuclear family structure. The qualitative findings concluded that uncertainty, academic challenges, helplessness and lack of mental health were the major concerns for the youth during the pandemic. Quality time with family and increased productivity came out as the positive trends during the pandemic times.

Limitations

The empirical findings reported herein should be considered in the light of some limitations; that could be addressed in future research. Exploring sample differences on variables like gender, SES was gone beyond the scope of current study's data analysis. Also exploring the cultural differences on the basis of caste or religion was originally not included as one of the objectives. India, majorly being the representative of the ‘collectivist culture’; this could have brought additional valuable insights.

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Implications and Recommendations

The study findings suggest that the youth were affected by their experiences during COVID-19, pointing to differences in the urban and rural populations. Besides the academic challenges faced, the psychological impact on daily life with uncertainties about the future means that preparedness for any pandemic needs to consider: i) policies to mitigate the mental health of young people; ii) devise urgent strategies for the provision of mental health services, and iii) creation and implementation of effective mental health programmes targeted at young people. The results also suggest the need for further research into the gender differences and an India-wide programme of research among the youth population.

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